Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-5237-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: OLD REPUBLIC INSURANCE CO Box #: 42	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Position Summary not submitted

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Amount in Dispute: $453.16

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: A response to the Medical Fee Dispute request was not submitted.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
Unknown	EOBs or denial letter not submitted by either party	AMOX	$ 65.00	$0.00
Unknown	EOBs or denial letter not submitted by either party	Walker	$ 40.00/mo	$0.00
05/05/10	EOBs or denial letter not submitted by either party	Prescription medication – Ondansetron HCL	$ 67.59	$0.00
05/05/10	EOBs or denial letter not submitted by either party	Prescription Medication – Hydrocodone/APAP	$ 30.99	$0.00
06/15/10	EOBs or denial letter not submitted by either party	Prescription Medication – Sulfameth/TMP DS TAB	$ 12.09	$0.00
06/15/10	EOBs or denial letter not submitted by either party	Prescription Medication - Ibuprofen 600 MG	$ 10.99	$0.00
06/15/10	EOBs or denial letter not submitted by either party	Prescription Medication – Ibuprofen 800 MG	$1 0.99	$0.00
05/10/10 – 06/0910	EOBs or denial letter not submitted by either party	1 month rental on Knee Walker	$102.84	$0.00
06/09/10 – 07/08/10	EOBs or denial letter not submitted by either party	1 month rental on Knee Walker	$102.84	$0.00
07/09/10 – 08/08/10	EOBs or denial letter not submitted by either party	1 month rental on Knee Walker	$102.84	$0.00

08/03/10	EOBs or denial letter not submitted by either party	Hydrocodone/APAP 5-500 Tablet	$ 11.99	$ 0.00
Unknown	EOBs or denial letter not submitted by either party	OAD Therapy Center – Self Pay	Unknown	$0.00
Unknown	EOBs or denial letter not submitted by either party	Tom Laundry Sports Medicine – PT Eval	Unknown	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §133.270 sets out the fee guidelines for the reimbursement of the out-of-pocket expenses incurred by the injured employee for their workers' compensation injury.

Issues

1. Did the requestor submit the request for medical dispute resolution timely in accordance with 28 Tex. Admin. Code §133.307?
2. Did the requestor incur out of pocket expenses?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Admin. Code Section §133.307(c)(1)(A) the request for medical fee dispute resolution was received by the Division on August 20, 2010; the dates of service in dispute range from 05/15/10 through 08/08/10. Therefore, this dispute was submitted in a timely manner.
2. Included in the injured employee's request for dispute resolution is a copy of an IRO request. It is unclear if the injured employee filed a request for a review by an Independent Review Organization before the request for medical fee dispute resolution was made.
3. The requestor has not submitted receipts showing the claimant incurred out-of-pocket expenses for AMOX, the walker, the OAD Therapy Center or Tom Laundry Sports Medicine; therefore, these services will not be reviewed.
4. In accordance with 28 Tex. Admin. Code §133.270(a-b) an injured employee may request reimbursement from the insurance carrier when they have paid for health care provided for a compensable injury. The request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider.
5. According to 28 Tex. Admin. Code §133.307(c)(3)(D) an employee who has paid for health care may request medical fee dispute resolution of a refund or reimbursement request that has been denied. The employee's dispute request shall be sent to the MDR Section by mail service, personal delivery or facsimile and shall include a copy of the carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received convincing evidence of the employee's attempt to obtain reimbursement or refund from the carrier or health care provider.
6. Review of the requestors submitted documentation does not support that an initial request for reimbursement was made. Included in the injured employees' documentation is a facsimile transmission form to the injured worker's adjustor; however, there is no fax confirmation sheet to support the request for reconsideration was made.

7. **Conclusion** For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270
Texas Administrative Code Sec. §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		01/21/11
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.